HB-0628-0403q

State of New Jersey - Department of the Treasury
Division of Pensions and Benefits

STATE HEALTH BENEFITS PROGRAM

Return to: HIPAA Privacy Officer
State Health Benefits Program
PO Box 295
Trenton, NJ 08625-0295

PARTICIPANT REQUEST FOR RESTRICTIONS
ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Participant Name: _____
LAST FIRST MI

Address: _____

_____

Daytime Telephone Number: _____ **E-mail:** _____
AREA CODE

Participant Identification Number or Social Security Number: _____

I, _____, am requesting a restriction on the State Health Benefits Program's (SHBP) use and/or disclosure of my health information (protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act [HIPAA] of 1996) in the manner described below. I understand that the SHBP may deny this request for any reason. I also understand that if agreed to, the SHBP may not be able to honor this request if I require emergency treatment and that the the SHBP may remove this restriction in the future, if I am notified in advance.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict:

_____

_____

Persons/Organizations Restricted from Use and/or Disclosure of Health Information. I request that the following person(s) and/or organization(s) not be allowed to use, receive and/or disclose the health information described above.

_____

_____

PARTICIPANT'S SIGNATURE

By signing this form, I am confirming that it accurately reflects my wishes.

_____ **Date:** ____/____/____
PARTICIPANT'S SIGNATURE MM / DD / YYYY

If signed by a personal representative, complete the following:

Name of Personal Representative: _____

Relationship to Participant or Nature of Authority: _____
(e.g., health care power of attorney, guardian, other statutory authorization):

Address: _____

_____

Daytime Telephone Number: _____ **E-mail:** _____
AREA CODE

_____ **Date:** ____/____/____
SIGNATURE OF PERSONAL REPRESENTATIVE MM / DD / YYYY